Policy Directions in New York State

Questions from the Audience and Panel Summary

Questions from the Audience

Question

I'd like to ask each one of the presenters to look at the situation in the West Coast; they have had managed care for longer than has the State of New York. Describe to me what you feel are one or two of the biggest weaknesses or problems with the systems in California and what your organizations are doing to avoid those problems.

SCHIMKE: California and other states have had considerably more experience than we have, particularly with the commercial population. Everybody is learning about the Medicaid population. They have had issues of capacity. One of the areas that California has not addressed, and that needs to have addressed, has been meeting the needs of those with special needs, particularly HIV and AIDS.

ROBERTSON: Much of what we are doing has been based on some of the good things we saw in California, but one of the bad things we saw in their experience was the form of capitation. We don't think capitation is the way to reduce the cost of care. We have taken a longer and different approach, which involves informing and educating providers about how to reduce duplication and unnecessary referrals, to improve both quality and outcome of care.

ROSENSTEIN: One of the mistakes that we make when we look at California is that we assume that the California market-

place is homogenous. It is not. Southern California's definition of managed care is different than northern California's definition. By and large in northern California, it has been significantly discounted fee for service. That is how it started in southern California but there have been more capitation models in southern California. We believe that the future is in managing risk and taking capitation and managing utilization within that capitated environment.

LEVIN: California has had its problems. One of its responses, I'm glad to hear, is that the state is providing an 800 number in answer to some of the problems that have surfaced there in terms of enrollee grievances.

Question

I'd like to ask a question about for-profit providers coming into New York State; that is, the hospital for-profit companies. What is the Pataki Administration's position on that?

SCHIMKE: The issue of for-profits coming into New York obviously is on many minds, including the Governor's. The Health Department does not have a position on that at this time.

ROBERTSON: Being a for-profit organization does not necessarily make you bad, nor does not-for-profit status necessarily mean you are doing something good. There tends to be a lack of efficiency in the not-for-profit model. I think both the for-profits and not-for-profits can produce quality products.

ROSENSTEIN: From the point of view of the academic medical centers, this is one regulation we would like to see the state keep in place. We believe that this market is moving fast enough. If you put the for-profits into the formula it will move even faster. I don't know of anybody who can keep up with that.

LEVIN: Some for-profit corporations are thriving in New York State. Advocates would continue to oppose changing current regulations to admit for-profit hospitals to New York State.

Question from the Associate Director of Emergency Medicine at Lincoln Hospital, South Bronx

In the emergency room we are at the cutting edge of what happens to the people who are not being represented on either side. We have a perfect case that illustrates what happens with denial of health care.

A 12-year-old girl came in from a shelter, with her mother. She belongs to an HMO that denies authorization for an emergency visit. But, as is our policy, we tend to just take the visit and swallow the cost anyway. It turns out she had meningococcal meningitis. If she had gone back to the shelter, there could have been a major public health dilemma.

Second, it's important to support graduate medical education because if we're talking about quality health care in the year 2000, 2002, if we're not training doctors to be able to perform adequate health care, we're not going to have any system to fall back on.

Finally, I want to bring up an issue that hasn't had a lot of the play in the media and that's the issue of asthma. At Lincoln Hospital last year we had 15,000 visits for asthma: 15,000 as opposed to 8,000 visits in our clinic setting. Talk about primary care being turned on its ear! That's a major issue. We're looking for solutions to that and at this point we haven't gotten very far. We set up a special clinic for the asthmatics but only 20% showed up so that to me is the seminal challenge for anybody who wants to come in— managed care, for-profit, not-for-profit, or otherwise.

We who are on the front lines in the inner city should be represented in this debate. It's very busy and a lot of work there but that's not what scares us as much as the fact that things like Medicaid reimbursement being cut back can definitely damage the ability to put people on the front lines. No matter what system we end up with, we have to protect the front lines.

SCHIMKE: The graduate medical education issue is very much on the minds of everybody. Clearly there is some interest in refocusing on graduate medical education for primary care.

Question

I'm very curious to know how the different players in the marketplace on health care view the uninsured populations.

ROBERTSON: That is a major problem. Unless we all figure out how to do a better job delivering care, none of us are going to be able to afford the cost. That is a major issue and deserves our society's attention. I'm always concerned about the very negative press that managed care is getting because I think managed care truly does offer some solutions to providing quality care in a cost-effective manner.

SCHIMKE: The number one concern that most people have is about uncompensated care and care for the uninsured. Until we get to a point where we have something more universal, this will continue to be the number one concern. There needs to be a continuing commitment to that public good. The focus of the expenditures that have been called "bad debt" and "charity care" needs to move away from operating losses for hospitals. They need to move to primary care. They need to move to connections to people, individual people who are uninsured, and they need to place an emphasis on buying insurance for those people.

Panel Summary

LEVIN: The confluence of a number of things that are going on in this country spell danger to me and to other advocates: if we move too fast into this new system of care, we may be heading for trouble. Managed care, taken not out of context but in context with all the other things that are going on at the federal and state level, should give us reason and pause for great concern. People who believe similarly must get involved in the legislative process of trying to protect people from harm.

ROSENSTEIN: We all agree, essentially, on what that direction of change is, but the issue is, how do we manage the change? There are pitfalls that we have to be very careful about and, from our perspective, we must look to the state to either regulate,

deregulate or even over-regulate at times in order to protect the system and to protect the providers and to protect the consumers.

ROBERTSON: I feel a strong sense of commitment to deliver to the consumers quality health-care products; to work with academic medical centers to determine, by teaching programs in the managed-care environment, how the state will fulfill its commitment; and to deliver and improve the health status of the Medicaid recipients in the city.

SCHIMKE: Why did New York State take the steps it has taken? To improve the health care status of New Yorkers and to improve the public health of New Yorkers. We have four very specific goals: to improve access; to assure quality; to contain costs; and to meet the requirements of those with special needs.

I think when we do that in New York State, we will have succeeded with managed care. I think we can.